WASHINGTON STATE REPORTING REQUIREMENTS

AIDS and HIV infection are reportable to local health authorities in Washington in accordance with WAC 246-101. HIV/AIDS cases are reportable within 3 working days and reporting does not require patient consent.

ASSURANCES OF CONFIDENTALITY AND EXCHANGE OF MEDICAL INFORMATION

- Several Washington State laws pertain to HIV/AIDS reporting. They include: Maintaining individual case reports for AIDS and HIV as confidential records (WAC 246-101-120,520,635); protecting patient identifying information, destroying identifying information on asymptomatic HIV-infected individuals after 90 days (WAC 246-101-230, 520, 635); investigating potential breaches of confidentiality of HIV/AIDS identifying information (WAC 246-101-520) and not disclosing HIV/AIDS identifying information (WAC 246-101-120, 230, 520, 635 and RCW 70.24.105).

- Health care providers and employees of a health care facilities or medical laboratories may exchange HIV/AIDS information in order to provide health care services to the patient and release identifying information to public health staff responsible for protecting the public through control of disease (WAC-246-101-120, 230 and 515; and RCW 70.24.105).

- Anyone who violates Washington State confidentiality laws may be fined a maximum of $10,000 or actual damages; whichever is greater (RCW 70.24.080-084).

FOR PARTNER NOTIFICATION INFORMATION

- Washington state law requires local health officers and health care providers to provide partner notification assistance to persons with HIV infection (WAC 246-100-209) and establishes rules for providing such assistance (WAC 246-100-072).

- For assistance in notifying spouses, sex partners or needle-sharing partners of persons with HIV/AIDS, please call HIV/AIDS Prevention & Education Services, DOH, at (360) 236-3422, or your local health department. In King County, please call Edith Allen, Public Health Seattle & King County, at (206) 731-4377.

Return completed form to:

Local Health Department

For address of local health department in your county call the state health department office:

Olympia (360) 236-3419
Kent (253) 395-6731
Toll free number 888-367-5555

FOOTNOTES

[1]Patient identifier information is not sent to CDC.

[2]Outpatient dx: ambulatory diagnosis in a physician's office, clinic, group practice, etc.

Inpatient dx: diagnosed during a hospital admission of at least one night.

[3]After 1977 and preceding the first positive HIV antibody test or AIDS diagnosis.

[4]If case progresses to AIDS, please notify health department.

[5]If further clarification of definitive and presumptive diagnostic methods is needed, please contact health department.

[6]Chronic: more than one month's duration.

[7]Recurrent: 2 or more episodes within a 1-year period.

[8]Wasting syndrome due to HIV infection includes >10% weight loss plus 1) chronic diarrhea and/or 2) fever and chronic weakness lasting over 30 days in absence of a concurrent illness other than HIV which could explain the findings (e.g., cancer, TB, cryptosporidiosis, or other specific enteritis).

FOR HEALTH DEPARTMENT USE ONLY

ID Code			
FUI Assigned:			
☐ Complete	☐ Incomplete	☐ OOS	
RVCT Number:			

CLINICAL AIDS

☐ CHECK HERE IF PATIENT HAS NO AIDS INDICATOR DISEASES
If checked, skip Clinical AIDS section.

Disease	Dx Date (mo/yr)	dx method[6] Presumptive	dx method[6] Definitive
Candidiasis, bronchi, trachea, or lungs	____/____		☐
Candidiasis, esophageal	____/____	☐	☐
Cervical cancer, invasive	____/____		☐
Coccidioidomycosis, disseminated or extrapulmonary	____/____		☐
Cryptococcosis, extrapulmonary	____/____		☐
Cryptosporidiosis, chronic[6] intestinal	____/____		☐
Cytomegalovirus disease (other than liver, spleen, or nodes)	____/____		☐
Cytomegalovirus retinitis (with loss of vision)	____/____	☐	☐
HIV encephalopathy	____/____		☐
Herpes simplex: chronic[6] ulcers; or bronchitis, pneumonitis, or esophagitis	____/____		☐
Histoplasmosis, diss. or extrapulmonary	____/____		☐
Isosporiasis, chronic[6] intestinal	____/____		☐
Kaposi's sarcoma	____/____	☐	☐
Lymphoma, Burkitt's (or equivalent)	____/____		☐
Lymphoma, immunoblastic (or equivalent)	____/____		☐
Lymphoma, primary in brain	____/____		☐
Mycobacterium avium complex or M. kansasii, diss. or extrapulmonary	____/____	☐	☐
M. tuberculosis, pulmonary	____/____	☐	☐
M. tuberculosis, diss. or extrapulmonary	____/____	☐	☐
Mycobacterium of other or unidentified species, diss. or extrapulmonary	____/____	☐	☐
Pneumocystis carinii pneumonia	____/____	☐	☐
Pneumonia, recurrent[7]	____/____	☐	☐
Progressive multifocal leukoencephalopathy	____/____		☐
Salmonella septicemia, recurrent	____/____		☐
Toxoplasmosis of brain	____/____	☐	☐
Wasting syndrome due to HIV[8]	____/____		☐

Comments:

CONFIDENTIAL HIV/AIDS ADULT CASE REPORT

Patient Name[1] (Last, First, Middle):

AKA (Nickname, Previous Last Names, etc.)

Phone #: __ __

Social Security #: . __ __

Current Street Address:

City: | Zip Code: | [1] Alive [2] Dead

Birthdate (mo/day/yr) / / | Death Date (mo/day/yr) / / | State of Death:

Sex at birth: [1] Male [2] Female

Gender or identity change: [1] Male to Female [2] Female to Male [3] Other

Ethnicity: [1] Hispanic [2] Not Hispanic

Race (check all that apply):
- ☐ White
- ☐ Black
- ☐ Asian
- ☐ Hawaiian/Pacific Islander
- ☐ Amer. Indian/Alaska Native

Marital Status:
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Never married
- ☐ Unknown

Country of birth: ☐ U.S. ☐ Other: _____

Was patient dx in another state? [1] Yes [2] No
If yes, specify state:

Residence at time of diagnosis if different than current address:
City: County: Zip Code:

Med. Record #/Patient Code:

Name & City of facility of diagnosis:

[1] Outpatient dx[2] [2] Inpatient dx[2]

PROVIDER INFORMATION

Physician: Phone: City:

Person reporting if other than physician: Phone:

PATIENT HISTORY SINCE 1977[3]

Check all that apply	Yes	No	Unk
Sex with male	☐	☐	☐
Sex with female	☐	☐	☐
Injection drug use	☐	☐	☐
Received clotting factors for hemophilia	☐	☐	☐
Transfusion, Transplant, or Insemination	☐	☐	☐
Heterosexual relations with:			
Injection drug user	☐	☐	☐
Bisexual man	☐	☐	☐
Person with hemophilia	☐	☐	☐
PWA/HIV transfusion or transplant	☐	☐	☐
PWA/HIV, risk not specified	☐	☐	☐
Worked in health-care or laboratory setting.. If yes, occupation:_____	☐	☐	☐

LABORATORY DATA[4]

Test Date (mo/yr)

Last documented negative test ____/____ Type of test:

EARLIEST POSITIVE HIV ANTIBODY TESTS:

Type of Test: Test Date (mo/yr)

HIV-1 EIA ____/____ ☐ Test not done

HIV-1 Western Blot or IFA ____/____ ☐ Test not done

HIV VIRAL LOAD TESTS:

Type of Test: Test Date (mo/yr)

Earliest HIV Viral Load ____/____ ☐ Copies per mL _____ ☐ Undetectable

Most recent HIV Viral Load ____/____ ☐ Copies per mL _____ ☐ Undetectable

OTHER HIV TESTS

Type of test: Rapid, Antigen, Culture, HIV-2, _____

Date (mo/yr): _____/_____ Result:

PHYSICIAN DIAGNOSIS OF INFECTION:

No laboratory tests are available but Physician documents HIV infection Date (mo/yr): _____/_____

CD4 LEVELS

Type of Test:	Test Date (mo/yr)	Count	Percent
Earliest CD4	____/____	_____cells/µl	_____%
Most Recent CD4	____/____	_____cells/µl	_____%
First CD4 <200 µl or < 14%	____/____	_____ cells/µl	_____%

TREATMENT / SERVICES REFERRALS

	Yes	No	Unk	NA
Has this patient been informed of his/her HIV infection?	☐	☐	☐	
This patient is receiving or has been referred for:				
• HIV related medical service	☐	☐	☐	
• HIV Social Service Case Management	☐	☐	☐	
• Substance abuse treatment services	☐	☐	☐	☐
This patient received or is receiving:	☐	☐	☐	
• Anti-retroviral therapy	☐	☐	☐	
• PCP prophylaxis	☐	☐	☐	

Per WAC 246-100-072, the local health officer is required to contact the health care provider within 7 days to offer partner notification assistance to all newly reported cases.

☐ Check this box if the patient has already been referred to the local health department for partner notification assistance.

FOR WOMEN

	Yes	No	Unk
Is this patient currently pregnant?	☐	☐	☐

Expected delivery date (mo/day/yr) _____ / _____ /_____

Note AIDS indicator diseases on reverse

HEALTH DEPARTMENT USE ONLY

☐ HIV ☐ AIDS Stateno: _____

Date: ____ / ____ /____ Source: _____

☐ New Case ☐ Progression ☐ Update, no status change

HIV TESTING HISTORY

Complete this section if new diagnosis or new patient OR attach completed questionnaire ☐ ***Not applicable***

Date of interview/questionnaire completion (mo/day/yr): ____/____/_____

FIRST SELF-REPORTED POSITIVE HIV TEST

Date (mo/yr): _____/_____

Registration type: ☐ Confidential ☐ Anonymous ☐ Refused ☐ Unknown

Site name:_____ State: _____

Circle type of facility:
1-HIV counseling/testing, 2-STD clinic, 3-Drug treatment clinic, 4-Family planning clinic, 5-Prenatal/OB clinic, 6-TB clinic, 7-Community health clinic, 8-Prison/jail, 9-Hospital/private MD, 10-Blood bank, 11-Outreach/mobile, 12-Emergency room, 13-Other

Reason for HIV testing when first positive *(answer all)*:

	Yes	No
Possible exposure to HIV in past 6 months	☐	☐
Time for regular test	☐	☐
Checking to make sure negative	☐	☐
Required by court, military, insurance, etc	☐	☐
Other _____	☐	☐

FIRST EVER HIV TEST

Date (mo/yr) (regardless of result): _____/_____

LAST SELF-REPORTED NEGATIVE HIV TEST

☐ Never had negative HIV test ☐ Refused ☐ Unk *(Skip to next section)*

Date (mo/yr): _____/_____

Site name:_____ State: _____

Circle type of facility:
1-HIV counseling/testing, 2-STD clinic, 3-Drug treatment clinic, 4-Family planning clinic, 5-Prenatal/OB clinic, 6-TB clinic, 7-Community health clinic, 8-Prison/jail, 9-Hospital/private MD, 10-Blood bank, 11-Outreach/mobile, 12-Emergency room, 13-Other

OTHER HIV TESTS

Number of HIV tests in 2 years before first positive (include first positive result):

1 (first positive test) + _____ (# of negative tests during prior 2 years) = _____ (total # of tests in 2 years)

ANTIRETROVIRAL USE BEFORE DIAGNOSIS OF HIV

	Yes	No	Ref	Unk
Used ARV in 6 months before diagnosis:	☐	☐	☐	☐

If yes: Names of medications used: _____
Continue in comments on reverse if necessary

First date of ARV use (mo/day/yr): _____/_____/_____

	Yes	No	Ref	Unk
Currently using ARV:	☐	☐	☐	☐

If no: Last date of ARV use (mo/day/yr): _____/_____/_____

[1, 2, 3, 4] Footnotes on reverse

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